No. 79-505

# In the Supreme Court of the United States

OCTOBER TERM, 1979

UNIHEALTH SERVICES CORPORATION, PETITIONER

*v.*

PATRICIA ROBERTS HARRIS, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ET AL.

*ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT*

## BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

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## OPINIONS BELOW

The order of the court of appeals (Pet. App. 1a) is not reported. The opinion of the district court (Pet. App. 4a-21a) is reported at 464 F. Supp. 811. An earlier opinion of the district court (Pet. App. 22a-59a) is reported at 448 F. Supp. 1059.

## JURISDICTION

The judgment of the court of appeals was entered on June 27, 1979. The petition for a writ of certiorari was filed on September 25, 1979. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## QUESTION PRESENTED

Whether the district court had jurisdiction to review a dispute between petitioner and the Department of Health, Education, and Welfare concerning the proper method of determining the "reasonable cost" of services rendered by petitioner to providers of medical services under the Medicare Act.

## STATEMENT

1. The Health Insurance for the Aged Act (codified in Title XVIII of the Social Security Act and commonly known as the Medicare Act), 42 U.S.C. 1395 *et seq.*, requires the Secretary of Health, Education, and Welfare to reimburse qualified providers of health care for the "reasonable cost" of the medical services they furnish to eligible Medicare beneficiaries. 42 U.S.C. 1395f(b). Reasonable cost is defined as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services * * *." 42 U.S.C. 1395x(v)(1)(A). The statute further provides that reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included * * *." *Ibid.* Under the authority conferred by 42 U.S.C. 1395hh, the Secretary has promulgated regulations specifying the method for determining the reasonable cost of medical services furnished by a provider. 42 C.F.R. 405.401-405.488. In addition, the Secretary has published various interpretive "Health Insurance Manuals" in order to provide further detail on the proper application of the Medicare statute and regulations. One of these, Health Insurance Manual-15 (HIM-15), entitled the "Provider Reimbursement Manual," contains guidelines for the implementation of the statutory and regulatory requirement that Medicare providers be reimbursed only for the reasonable cost of providing care to Medicare beneficiaries.



The Manual explains that, in some situations, the propriety of reimbursing a provider for fees it has paid to private companies for services or supplies can be determined only after a detailed analysis of each specific service or supply, its appropriate price if purchased separately, and its relationship to patient care. For example, Section 2404.2F of the Manual describes the obligations of a provider seeking reimbursement for "management services" obtained from a private entity. The section states:

> Where a provider pays a fee for management services, such provider must identify the services furnished in sufficient detail for the health insurance program to determine that these services, for which reimbursement is sought from the program, are necessary and proper * * * for the production of patient care services and that the costs are reasonable.
>
> Under this provision, the financial intermediary that actually dispenses Medicare funds to the provider (*i.e.*, "the health insurance program" (see 42 U.S.C. 1395h)) may request whatever information it deems necessary to enable it to determine whether the provider's management service fees should be reimbursed. In some instances, the intermediary may conclude, even without a detailed description of the specific management services obtained from a private entity, that a particular provider's management service fee is a proper and reasonable cost incurred in the delivery of patient care services. In other instances, more complete information may be required before a reimbursement decision can be made.

The Provider Reimbursement Manual establishes a category of service organizations called "franchisors" whose fees charged to a provider cannot be reimbursed unless the provider describes in detail each service performed for the fee and the intermediary determines on the basis of that information that the service is necessary and proper for the production of patient care services and that the cost of the service is reasonable. See HIM-15, Section 2133. To be classified as a "franchisor" within the meaning of the Manual, a service entity need not qualify as a "franchise" under state law; rather, the critical consideration is whether the nature of the service operation and the relationship between the service company and the provider create reason to believe that a portion of the fees paid by the provider to the service company is attributable not to the reasonable cost of management services actually rendered, but to some factor unrelated to the production of patient care services, such as the provider's right to use the service company's name or logo.

The only significant difference, then, between a financial intermediary's review of franchise fees and its review of management fees paid to a non-franchise service company is that detailed, component-by-component scrutiny is *required* in a franchise arrangement and merely *permissible* at the intermediary's discretion in a non-franchise situation.

2. Petitioner is a private, profit-making corporation formed to provide certain services to Medicare providers in the home health agency category, as defined in 42 U.S.C. 1395x(m), (n), (*o*). Petitioner services 25 provider clients in a 17-state area and the District of Columbia (Pet. App. 24a). Petitioner charges each of its client



agencies a fixed percentage of the agency's gross billings. The percentage is established by contract in advance and allegedly covers "initial startup fees; professional consultation and orientation program; continued management services; manuals; forms; brochures; other teaching tools; as well as guidance and aid in all financial matters; data processing; billing services and preparation of cost and periodic interim payment reports; and assistance in audit procedures conducted by fiscal intermediaries" (Pet. App. 24a-25a). Petitioner has agreed that it will refund to the providers any portion of its fees for which the providers are not reimbursed under the Medicare program (*id.* at 25a).

Before 1977, petitioner was not treated as a franchisor. As a consequence, the fees it charged to its client agencies apparently were not reviewed with the detailed scrutiny required for franchise fees, and the providers obtained full reimbursement.[1] In 1977, the Social Security Administration informed financial intermediaries that petitioner should be treated as a franchisor. Petitioner complains that this policy decision has been applied retroactively and has affected the intermediaries' review of fees charged for services rendered during the years 1974, 1975, and 1976. Petitioner further alleges that, as a result of the increased financial scrutiny required by its franchisor classification, its client agencies have withheld payment of fees due in a total amount of $800,000 (Pet. App. 5a-6a, 8a, 27a).

Petitioner brought this suit in the United States District Court for the Eastern District of Louisiana, challenging the federal respondents' decision to treat it as a franchisor. Petitioner alleged that that decision violated

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[1]In light of the current procedural posture of this case, we assume that the allegations in petitioner's complaint are true.

its rights under the Due Process Clause in a variety of ways summarized by the district court at Pet. App. 8a-9a. Relying on *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F. 2d 328 (5th Cir.) (en banc), cert. denied, 439 U.S. 893 (1978), and *American Association of Councils of Medical Staffs* v. *Califano*, 575 F. 2d 1367 (5th Cir. 1978), cert. denied, 439 U.S. 1114 (1979), the district court dismissed the complaint for lack of jurisdiction. The court held (Pet. App. 20a) that the Medicare Act, by virtue of its incorporation of Section 205(h) of the Social Security Act (see 42 U.S.C. 405(h), 1395ii), precludes the district courts from exercising jurisdiction over petitioner's claims under 28 U.S.C. 1331. The court of appeals affirmed (Pet. App. 1a).

**ARGUMENT**

Petitioner's principal assertion seems to be that the district court erred in holding that it lacked jurisdiction under 28 U.S.C. 1331. See Pet. 29. Petitioner is plainly wrong. This Court held in *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975), that Section 1331 does not confer jurisdiction over cases arising under Title II of the Social Security Act, because Section 205(h) of the Act excludes all sources of jurisdiction other than that provided in Title II itself. See 42 U.S.C. 405(g), (h). The Medicare Act incorporates Section 205(h) (see 42 U.S.C. 1395ii), and therefore jurisdiction under Section 1331 is unavailable to petitioner.[2] See also *Mathews* v. *Eldridge*,

[2]The same reasoning applies to petitioner's assertion that jurisdiction lies under 28 U.S.C. 1332 and 1361 (Pet. 14-16, 25-26). As the Court noted in *Salfi* (422 U.S. at 756 n.3), at the time Section 205(h) was enacted, 28 U.S.C. 41 contained all of the Judicial Code's general grants of jurisdiction to the federal district courts. By precluding suits under 28 U.S.C. (1934 ed.) 41, therefore, Congress intended to make the Social Security Act itself the sole source of jurisdiction over actions to recover on claims arising under Title II. (The question whether 28 U.S.C. 1361 can serve as a jurisdictional base for a suit arising under Title II was presented in *Califano* v. *Yamasaki*, No. 77-1511 (June 20, 1979), but the Court decided the case without reaching that issue.)



424 U.S. 319, 326-332 (1976). In a case decided 11 months before this one, the court of appeals held that these principles preclude review in the district court of challenges to the constitutionality of regulations and guidelines implementing the Medicare Act unless that Act itself grants jurisdiction (as it does, for beneficiaries and providers, in 42 U.S.C. 1395ff and 1395*oo*). *American Association of Councils of Medical Staffs* v. *Califano*, 575 F. 2d 1367 (5th Cir. 1978), cert. denied, 439 U.S. 1114 (1979). The Court denied review in that case, and there is no greater reason to grant review here. See also *Drennan* v. *Harris*, 606 F. 2d 846 (9th Cir. 1979).

Petitioner suggests (Pet. 22-23) that if 42 U.S.C. 1395ii deprives it of judicial review, then that statute is unconstitutional. This Court has enforced review preclusion statutes. See, *e.g.*, *Union Pacific R.R.* v. *Sheehan*, 439 U.S. 89 (1978); *Briscoe* v. *Bell*, 432 U.S. 404 (1977). But the present case does not require the Court to consider the constitutionality of such provisions as a general matter. The courts below did not hold that all forms of judicial review are precluded.

This suit is a request for judicial relief filed by a corporation that is not directly affected by the fee review procedures in question. Petitioner is not a provider and does not seek to become one. Petitioner asserts only that Medicare reimbursements to its provider clients are affected by the Secretary's instructions to financial intermediaries and that, because of its contractual relations with its clients, it in turn is financially affected.

Petitioner, in other words, contends that it may suffer incidental consequences as a result of determinations concerning the reimbursement due to its provider clients. The providers to whom these determinations directly apply can themselves obtain administrative and judicial review of the correctness and constitutionality of the determinations and the procedures by which they are reached. See 42 U.S.C. 1395*oo*.

Because it seeks to obtain review of an action by which it is incidentally affected, petitioner may have "standing" in the Article III sense. Compare *United States* v. *SCRAP*, 412 U.S. 669 (1973), with *Simon* v. *Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976). But no principle of constitutional law requires Congress to make judicial review available at the behest of *every* person who has Article III standing but is aggrieved only indirectly. It should be enough, in most circumstances, that the controversy is of a sort that can be resolved at the behest of some aggrieved party. That is true here, for the providers themselves may obtain judicial review of the policy decision challenged by petitioner.

Moreover, the district court did not reject the possibility that petitioner could assert its claim for damages in the Court of Claims (see Pet. App. 21a), and petitioner has in fact filed an action in that court raising the identical issues involved here.[3] Until this avenue of

[3]See *Unihealth Services Corporation* v. *United States*, No. 273-79C (filed June 27, 1979).

The Court of Claims has held that 28 U.S.C. 1491 gives it jurisdiction to review claims for damages arising out of the Medicare Act and the implementing regulations. See *Appalachian Regional Hospitals, Inc.* v. *United States*, 576 F. 2d 858 (1978); *Whitecliff, Inc.* v. *United States*, 536 F. 2d 347 (1976), cert. denied, 430 U.S. 969 (1977). On September 26, 1979, the government moved to dismiss petitioner's suit in the Court of Claims for want of jurisdiction, arguing that the court's earlier assertion of jurisdiction in *Whitecliff* was erroneous. This motion is pending.



relief has been fully explored, petitioner may not call on this Court to resolve whatever constitutional questions may lurk in an absolute preclusion of judicial review.

## CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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